

Kansas State Board of Pharmacy  
800 SW Jackson, Ste. 1414  
Topeka, KS 66612  
Phone: 785-296-4056  
Fax: 785-296-8420  
[www.kansas.gov/pharmacy](http://www.kansas.gov/pharmacy)

**APPLICATION FOR REGISTRATION  
PRESCRIPTION and CONTROLLED DRUGS DISTRIBUTOR**

**APPLICANT INSTRUCTIONS**

**Basic Requirements:** Requirements for registration are outlined in the Kansas Pharmacy Act, specifically K.S.A. 65-1645, K.S.A. 65-1655, K.A.R. 68-14-1 through K.A.R. 68-14-8. Statutes and Regulations can be found at [www.kansas.gov/pharmacy](http://www.kansas.gov/pharmacy).

**About the Application.** This application is to be completed by you and returned to the Kansas State Board of Pharmacy. All questions on the application are mandatory, and all supporting documents must be submitted with the application. You may copy as many forms as needed; however, each form submitted must be completed in original ink or typed. Be sure to keep a copy of the completed application for your records.

**Application good for One Year.** Your application will be kept on file for one year from date of receipt. You will need to resubmit a renewal form and fee after that time.

**Applicant Checklist:**

**For registration approval and changes to existing registrations, you must submit in one complete package:**

\_\_\_\_\_ **Completed application with the non-refundable application-processing fee.**

\_\_\_\_\_ **A copy of the current pharmacy license issued by the state of residence.**

\_\_\_\_\_ **Ownership List and Information.**

\_\_\_\_\_ **A copy of the most recent report of inspection conducted within the past two years by the Board of Pharmacy of the state of residence.**

Return your completed application packet and all supporting documents to:

Kansas State Board of Pharmacy  
800 SW Jackson, Ste.1414  
Topeka, KS 66612

FEE \$ 240.00

KANSAS STATE BOARD OF PHARMACY  
800 SW JACKSON ROOM 1414  
TOPEKA KS 66612  
(785) 296-4056  
FAX (785) 296-8420

FOR OFFICE USE ONLY

REG NO. \_\_\_\_\_

DATE \_\_\_\_\_

Check# \_\_\_\_\_ \$ \_\_\_\_\_

APPLICATION FOR **PRESCRIPTION DRUG /CONTROLLED SUBSTANCES DISTRIBUTION** REGISTRATION

This application is being made for the following reason: (Check all that apply) Effective Date \_\_\_\_\_

\_\_\_\_\_ Original \_\_\_\_\_ Change of Address \_\_\_\_\_ Change of ownership \_\_\_\_\_ Change of business name

If a Change of Address or Ownership: Previous License Number or Name (if applicable) \_\_\_\_\_

Or Previous Address \_\_\_\_\_

The owner hereby makes application as follows:

NAME OF OWNER \_\_\_\_\_ FEIN \_\_\_\_\_

ADDRESS OF OWNER \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX NUMBER \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

Type of ownership (Check one):

\_\_\_\_\_ **INDIVIDUAL**

\_\_\_\_\_ **PARTNERSHIP** Attach additional listing of each partner's name, address of record and % ownership.

\_\_\_\_\_ **CORPORATION** Attach additional listing of officer's name, title, address of record and % ownership.

\_\_\_\_\_ **LLC** Attach additional listing of members. Include name, title, address of record and % ownership.

\_\_\_\_\_ **OTHER** Indicate type: \_\_\_\_\_

The owner makes application for registration to ship prescription or controlled drugs into the State of Kansas under the name of and at the location as follows:

TRADE NAME/BUSINESS NAME USED BY THE ENTITY \_\_\_\_\_ Hours of Operation \_\_\_\_\_

**PHYSICAL ADDRESS** (Cannot be a private residence)

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COUNTY \_\_\_\_\_

TELEPHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_ WEBSITE \_\_\_\_\_

**MAILING ADDRESS** IF DIFFERENT THAN PHYSICAL LOCATION FOR RENEWAL INFORMATION

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_ FAX NUMBER \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

The owner names the following person as the contact agent/authorized representative to do business with the State of Kansas on the owner's behalf:

NAME OF CONTACT AGENT/AUTHORIZED REPRESENTATIVE

TITLE

TELEPHONE NUMBER

E-MAIL ADDRESS

**SERVICES PROVIDED** (Check all that apply)

\_\_\_\_\_ Prescription Drugs (noncontrolled) \_\_\_\_\_ Nonprescription drugs \_\_\_\_\_ Schedule II/Narcotic

\_\_\_\_\_ Schedule II/nonnarcotic \_\_\_\_\_ Schedule III/Narcotic \_\_\_\_\_ Schedule III/nonnarcotic

\_\_\_\_\_ Schedule IV \_\_\_\_\_ Schedule V (Includes Pseudo ephedrine, Ephedrine) \_\_\_\_\_ Other Devices & Supplies

**\* If Other-please describe devices being distributed on a separate sheet\***

**QUESTIONS**

1) In which other state(s) is your facility licensed? \_\_\_\_\_

2) Is the distributor registered with the appropriate state regulatory agency in the state of residence? \_\_\_\_ Yes \_\_\_\_ NO

3) Is the applicant registered by the DEA to ship controlled substances or Chemical I substances? \_\_\_\_ Yes \_\_\_\_ No

**\*\*\*If Yes please attach a copy of your DEA certificate.\*\*\***

In relation to the following questions, "applicant" includes the legal entity, which owns the distribution business as well as each individual, owner, partner, corporate officer, director, employee or associate.

4) Has the applicant been convicted under any federal, state, or local laws relating to drug samples, wholesale or retail drug distribution or distribution of a controlled substance? \_\_\_\_ Yes \_\_\_\_ No

5) Has the applicant been convicted or entered a plea of no contest to any felony under federal or state laws? \_\_\_\_ Yes \_\_\_\_ No

6) Has any license or registration, currently or previously held by the applicant been surrendered, suspended, revoked, or disciplined by federal, state or local government for the manufacture or distribution of any drugs, including controlled substances? \_\_\_\_ Yes \_\_\_\_ No

7) Has any applicant ever furnished false or fraudulent material in any application made in connection with drug manufacturing or distribution? \_\_\_\_ Yes \_\_\_\_ No.

**\*\*\*If any of the answers to the above are answered "yes" provide an attached detailed explanation along with any documentation.\*\*\***

8) Has applicant complied with registration requirements under previously granted registration, if any? \_\_\_\_ Yes \_\_\_\_ No.

9) Has applicant complied with requirements to maintain or make available to the Board or to federal, state, or local law enforcement officials those records required by the Federal Food, Drug and Cosmetic Act? \_\_\_\_ Yes \_\_\_\_ No.

10) Has each person employed in any prescription drug wholesale distribution activity had education, training or experience sufficient for that person to perform the assigned functions in such manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law? \_\_\_\_ Yes \_\_\_\_ No.

**\*\*\*If any of the answers to the above are answered "no," provide a detailed explanation along with any documentation.\*\*\***

What is the applicant's past experience in the manufacture or distribution of prescription drugs, including controlled substances? Provide A detailed explanation.

**AFFADAVIT**

I, \_\_\_\_\_, solemnly swear (or affirm) under the penalties of perjury, that I am the person authorized to sign this application for registration and that the statements and representations made in the foregoing application and all attachments are true and correct to the best of my knowledge and understands that this registration, if issued, will expire ANNUALLY on the 30th day of June and such registration will be cancelled if not renewed ANNUALLY by the 31<sup>st</sup> day of July.

\_\_\_\_\_  
SIGNATURE OF OWNER/OFFICER

Signed and sworn to (or affirmed) before me on \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

(Seal)

My commission expires \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF NOTARY PUBLIC